PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council, Tuesday, June 25, 2002, 10:00 a.m., Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts. Public Health Council Members present were: Dr. Howard Koh (Chairman), Ms. Phyllis Cudmore (arrived late at 10: 21a.m.), Mr. Manthala George, Jr., Ms. Shane Kearney Masaschi, Mr. Benjamin Rubin, Ms. Janet Slemenda, Dr. Thomas Sterne and Dr. Martin Williams, M.D.; Ms. Maureen Pompeo absent. Also in attendance was Attorney Donna Levin, General Counsel.

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Chairman Koh announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with the Massachusetts General Laws, Chapter 30A, Section 11A ½.

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The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Dr. Jean McGuire, Director, HIV/AIDS Bureau; Ms. Alexandria Kearns, Licensing Specialist, Bureau of Substance Abuse Services; Ms. Joyce James, Director, Determination of Need Program; and Attorneys Edward Sullivan and Tracy Miller, Deputy General Counsels, Office of the General Counsel.

RECORDS OF THE PUBLIC HEALTH COUNCIL:

Records of the Public Health Council Meeting of March 26, 2002 were presented to the Council. After consideration, upon motion made and duly seconded, it was voted (unanimously) to approve Records of the Public Health Council Meeting of March 26, 2002.

PERSONNEL ACTIONS:

In a letter dated June 6, 2002, Katherine Domoto, M.D., Associate Executive Director for Medicine, Tewksbury Hospital, Tewksbury, recommended approval of the reappointments to the medical staff of Tewksbury Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees'qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Associate Executive Director for Medicine of Tewksbury Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following reappointments to the various medical staffs of Tewksbury Hospital be approved for a period of two years beginning June 1, 2002 to June 1, 2004:

REAPPOINTMENTS	STATUS/SPECIALTY	MEDICAL LICENSE NO.

Neil Kowall, M.D.	Consultant Staff Neurology	46511
Daniel Berman, M.D.	Consultant Staff Radiology	73877
Dan Seligman, D.P.M	Consultant Staff Podiatry	1598
Alexandria Weida, Ed.D	Allied Staff Psychology	6594

In a letter dated June12, 2002, Carlton M. Akins, M.D., Medical Director, Philip E. Dould, Acting Chief Executive Director, and Arthur M. Pappas, M.D., Chairman, Board of Trustees, Massachusetts Hospital School, Canton, recommended approval of the reappointments to the various staffs of Massachusetts Hospital School. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Medical Director, Acting Chief Executive Director and Chairman of the Board of Trustees of Massachusetts Hospital School, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following reappointments to the various medical staffs of Massachusetts Hospital School be approved:

REAPPOINTMENTS	**STATUS/SPECIALTY**	**MEDICAL LICENSE NO.**
Carlton M. Akins, M.D.	Active/Orthopedics	31406
Anthony Atala, M.D.	Consulting/Urology	73062
Isabel M. Balmaseda	Allied Health Professional Pain Management Acupuncturist/Massage Therapist	551
Elizabeth D. Barnett, M.D.	Consulting/Infectious Diseases	58612
Stuart B. Bauer, M.D.	Consulting/Urology	36354
Sheila Bell, C.P.N.P.	Allied Health Professional Pediatric Nurse Practitioner	123456
John Bernardo, M.D.	Active/Pulmonary Medicine	44145
Joseph G. Borer, M.D.	Consulting/Urology	157718
Christine C. Campbell-Reardon, M.D.	Active/ Pulmonary Medicine	73469
Henry H. Cho, M.D.	Consulting/Physiatry (Rehabilitation Medicine)	38435
Bartley C. Cilento, M.D.	Consulting/Pediatric Urology	156057
Barbara Closs, M.S., R.N.C.S.	Allied Health Professional Pediatric Nurse Practitioner	238540
Kathleen Connolly, N.P.B.C.	Allied Health Professional Pediatric Nurse Practitioner	152188
Ellen R. Cooper, M.D.	Active/Infectious Diseases	56270
David A. Diamond, M.D.	Consulting/Urology	52996
Anton B. Dodek, M.D.	Active/Pediatrics	74229

MHS REAPPOINTMENTS	STATUS/SPECIALTY	MEDICAL LICENSE NO.
CONTINUED		
Murray Feingold, M.D.	Courtesy/Genetics	26641
Louisa Fertitta, M.S., R.N.C.	Allied Health Professional Nurse Practitioner	11674
John P. Ficarelli, D.M.D.	Active/Dentistry	12246
Geraldine C. Garcia-Rogers, D.M.D.	Active/Dentistry	19107
Steven W. Greer, M.D.	Courtesy/Pediatrics	70786
Sheela Gurbani, M.D.	Active/Neurology	49457
Jo-Ann Harris, M.D.	Consulting/Infectious Diseases	54148
Katherine K. Hsu, M.D.	Consulting/Infectious Diseases	156985
John T. Jones, Ph.D.	Allied Health Professional Psychology	4757
Diana L. King, Psy.D.	Allied Health Professional Psychology	4907
Jerome O. Klein,M.D.	Consulting/Infectious Diseases	27955
Wayne L. Klein, Ph.D.	Allied Health Professional Psychologist	6368
Frances J. Lagana, D.P.M.	Consulting/Podiatry	1882
David Levoy, M.D.	Active/Psychiatry	77123
Linda C. Loney, M.D.	Active/Pediatrics	55746
Karen Madden, N.P.B.C.	Allied Health Professional Pediatric Nurse Practitioner	174567
Peiman Mahdavi, D.M.D.	Active/Orthodontics	17965
Alan L. Morris, D.M.D.	Active/Periodontics	12926
Nasser Nabi, M.D.	Consultant/Cardiology	33570
Carolanne Oller-Chiang	Allied Health Professional Pain Management/Massage Therapist	2149
Scott F. Petrie, M.D.	Active/Dentistry	16601
Aruna Sachdev, M.D.	Active/Rehabilitation Medicine	50059
Arthur J. Schneider, M.D.	Consultant/Radiology	55721
Cathy Stern, O.D.	Allied Health Professional/Optometry	2816
Arthur M. Pappas, M.D.	Active/Orthopedics	27259
Alan B. Retik, M.D.	Consulting/Urology	29266
Thomas Cooper, M.D.	Active/Dermatology	55056
Benjamin E. Bierbaum, M.D.	Consulting/Orthopedics	28492

In a letter dated June 13, 2002, Paul D. Romary, Executive Director, Lemuel Shattuck Hospital, Jamaica Plain, recommended approval of an initial appointment to the medical staff of Lemuel Shattuck Hospital. Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Lemuel Shattuck Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the initial appointment to the medical staff of Lemuel Shattuck Hospital be approved as follows:

PHYSICIAN APPOINTMENT	**STATUS/SPECIALTY**	**MEDICAL LICENSE NO.**
Barbara Weinstein, M.D.	Active/Pathology	45724

STAFF PRESENTATION:

"NATIONAL HIV COUNSELING AND TESTING DAY: A REVIEW OF THE STATUS OF HIV TESTING IN MASSACHUSETTS," by Jean McGuire Ph.D., Director, HIV/AIDS Bureau:

Dr. Jean McGuire, Director of the HIV/AIDS Bureau, made a slide presentation to the Council. She reviewed state and national epidemic profiles, reviewed the role and performance of the publicly-funded HIV counseling and testing services in Massachusetts, identified program and policy innovations that her program has undertaken, and launched the HIV Testing Day Campaign. Dr. McGuire said in part, "…In the United States, the data indicates that there are approximately eight hundred to nine hundred thousand people living with HIV, as an estimate that the CDC has recently released. In Massachusetts, the corollary number would be between eighteen and twenty thousand people currently alive with the virus. According to the federal estimates one third of those individuals do not know their status. In Massachusetts, six thousand or more people are currently living with the virus and do not know their status or are not in care. We are very concerned about reaching those people. Why are we concerned? People who are co-diagnosed with AIDS, in other words they learn about their HIV status at the point that they already have AIDS, are missed opportunities for us, especially in a system where we have virtually no barriers to care as in this state. Thirty-six percent of people in Massachusetts are co-diagnosed within two months of one diagnosis and the national figure is forty-three percent co-diagnosed within a year. We are better than the national average. We have fewer people getting diagnosed that late. The number that we have getting diagnosed that late is unacceptable and it is an indication of a system failure. And we are reinvigorating our efforts around HIV counseling and testing, with the assistance of people living with the virus, in an effort to reduce that number further."

"Finally", Dr. McGuire continued, "the final number is one that we continue to be extremely concerned about. CDC has estimated forty thousand new infections a year. For our state relative to its percentage within the national epidemic, that's eight hundred new infections a year. That's two new infections each day. The CDC's goal by 2005 is to cut that in half. We have to seek to emulate that goal. Black and Hispanic people are ten times and eight times more likely to have HIV. Therefore, the importance of making sure that our services are available, accessible, and adequately used by people from Black, Hispanic and other minority communities is incredibly imperative for our bureau."

Dr. McGuire noted the goals of the Department's HIV/AIDS Bureau:

- Increase the number of people who know their status
- Early identification and treatment
- To have a voluntary community-based system for testing

Dr. McGuire further stated, "…In this state, testing is voluntary. That has been the hallmark of our system. It has been absolutely necessary, whether it has been in the community, in hospitals, in jails, or in treatment settings, to encourage people to come in and feel like they are making this decision of their own free will. It has been community-based so that it could be accessible to folks. It has been targeted in terms of what are the communities that are most at risk, and there has been an inclusive, complex array of service provision, from sexual and drug risk assessment through the specimen collections, through a post-test counseling and then the effective linkage of people to clinical and behavioral services. We fund over a hundred sites. They account for about twenty-five to thirty percent of all tests that are done annually in this state, but they disproportionally account for the test among highest risk individuals and, therefore, the tests are more of people who are actually positive. We do these tests in very diverse places, community-based organizations, shelters, health centers, food kitchens, and drop-in centers. We do some of the work in outreach and crack houses, and settings where people who are likely to be at great risk gather. We also determine where we put the resources and the services by epidemiology and by the cultural linguistic needs of the communities."

Dr. McGuire continued, "We have done almost four hundred and fifty thousand tests through our funded services over the last decade. During that period of time, the seropositivity rate has declined from about two and a half percent to one percent, which is consistent with what is happening nationally…There are multiple, social, fiscal, political and clinical influence that bring people into services, or make those services available. By 1992, federal funding availability and the efficacy of PCP prophylaxis and AZT had begun to significantly affect counseling and testing access, promotion and utilization. Magic Johnson's diagnosis occurred shortly thereafter and further expanded utilization. 1994 is the point where the efficacy of treating pregnant women and keeping their babies healthy prompted expansion of testing to pregnant women broadly in the country. This was shortly followed by the introduction of protease inhibitors, and really a sense that, the course of the disease and people's lives could change. Seeing people be healthier really has encouraged more people to want to know their status, and to believe that something useful could be done. During that period of time, we saw

an increase in the number of lower risk individuals coming, and the Department restructured and further targeted our access to services in a reprocurement process in 1997. That's why you see a decline there. That was consistent with federal directives regarding what should be our primary focus and how much we had to make sure that outreach happened in the right population….Ten years ago, people of color constituted only about twenty-five percent of those that were utilizing our services in spite of the fact that they had begun to significantly represent a larger proportion of the epidemic. Now, people of color constitute over fifty percent of those that are using our services, and that is approximately the same as what the overall epidemiology shows at the moment…In our efforts to reach more Blacks, Hispanics and Asians, we have gotten greater seropositivity among the individuals tested. Therefore, we have been succeeding in terms of going to the right people in the right places…"

Dr. McGuire noted the surveillance data in this state continues to show that men having sex with men, and intravenous drug users have the highest risk rates. People with STDs and individuals having sex with a person who has HIV or AIDS are also at risk. She further noted, "that the ability of an individual to disclose their status to somebody who they care about, their sexual partner, is incredibly important in terms of abating the expansion of this epidemic." "Stigma is something we are worried about," said Dr. McGuire. She cited some statistics from a review in the American Journal of Public Health by Dr. Herek on people's perception of people living with AIDS:

- one-fifth of those surveyed still fear people with AIDS;
- one-sixth express disgust or supported the public naming of individuals;
- one-half of respondents perceive people with AIDS to be responsible for their illness.

Dr. McGuire cited future strategies for improving the efficacy of counseling and testing:

- increased primary care testing for people who are at risk;
- increased oral mucosal testing in the community and in the jails;
- increased joint STD and Hepatitis C testing to address all the infectious risks that people are experiencing concomitantly;
- selective hospital-based urgent care testing consistent with CDC guidelines;
- review of rapid test product development;
- de-tuned assay assessment which show if the infections are recent;
- increased emphasis on partner counseling referral and support;
- ongoing prevention risk assessment;
- testing access message development (a good message is needed so that people will change their behavior).

Dr. McGuire spoke about National HIV Testing Day, which started in 1995, and this year's campaign which was drafted by consumers. Its says, ''Take Control of Your Health; Get Tested for HIV." It is a message from people living with the HIV virus to their communities, primarily communities of color. It addresses fear and stigma. It supports individual responsibility, and it emphasizes the availability of clinical and other care and support.

Ms. Shirley Royster, a consumer involved in spreading this campaign message, addressed the Council. She said, "Seventeen years ago, I fell in love. I fell in love and it was one of the best things that ever happened to me. My risk of HIV at that time was great. I had been an IV drug user. I was in recovery for seven years. I had no symptoms. I had never had pneumonia. I had never been sick. But, because the relationship was important to me, I decided I should go and get tested. And lo and behold, I was positive. I told that person immediately. I felt it was my obligation. I felt like I would not be true to myself or true to that person if I didn't tell them. I also gave them an opportunity, at that point, to leave because I didn't know what was going to happen to me. Seventeen years ago, no one could tell me how long I had to live, what medications I should have, or what was going to happen. And I have to tell you that that was the best thing that I ever did for myself. I sleep at night. I feel good about myself, and I am still in that relationship. They didn't leave me, but at that time I was afraid that that was going to happen. The next people that I told was my support group. I had a support group because I needed a support group, just to keep me healthy and just to keep me from being out in the street relapsing. And I told those people. And they didn't turn away from me. But just let me say this. I am one of the most fortunate people you will see because a lot of us are not like that. A lot of us, when we tell our family and friends, we no longer have those people as our support."

Ms. Royster continued, "My job is to go around to detox programs, transitional living programs and do peer education. This Friday, when I went to New Bedford to a detox program, I gave them basic education about how you get HIV. I told them about clean needles. I told them about using protection. I told them about abstinence. And one of the young men that was sitting there said to me, 'I would never go out with anybody who had HIV, never.' And I had just given him information about how you can keep yourself safe because, remember, you are the only person who can keep you from getting HIV, and he turned around and said that. But you know what it was – the fear. His fear was so great. It was not about the person who had HIV, it was about his own fear because I take my responsibility for having this virus and not passing it on to somebody else. That's why this campaign is so important to me. I was one of the people who sat at the Advisory Table to talk about how we, who have HIV, can take responsibility. It is also important for us to remember that, if you don't know your status, you can not take responsibility for it. You have to know it, and we have to be able to support people in order to give them that message, and that is why I am happy to be here today, and put my face on this campaign."

Mr. John Ruiz, a consumer working on spreading this campaign message, addressed the Council. Mr. Ruiz stated, "I have been living with HIV for 19 years. The first ten years of the nineteen years was spent not knowing my status, because back in 1983 a test was not available. But, I was always thinking that I was positive because I fit into a high risk group. Some of that time was also spent, once the test became available, wondering whether I should get tested or not. And then, once I got tested, I spent a whole year waiting to get my results. I didn't go back for my results for a whole year. And it was all because I was afraid. I had this fear of being discriminated against, fear of losing my job, fear of losing my housing, fear of being disowned by my family and shunned by the community, a community that I was deeply involved in, because I did a lot of community work back in he 1980s. Looking back, I realized that the issue at play was identified as stigma, HIV-related stigma, and that is what keeps a lot of people today from engaging in counseling and testing, from knowing their status. As Jean reported earlier, the study done by Dr. Herek shows that HIV-related stigma is still very prevalent in white suburban

communities. Now, we can imagine how prevalent it is in communities of color. From my experience, in communities of color, the prevalence has been higher. And for all the talk about stigma and all the papers written about it. There is still not a lot of interventions out there. This counseling and testing campaign is not just a way to draw people into testing and care but it is also a stigma intervention because four faces appear on this poster: Shirley's face, my face, Reverend Burke's face, and Rosalinda Pedrosa's face. We are all well know in the communities in which we live, and we are saying, you know, we are living with HIV, and we are living well with this disease because we got tested and we are in care. Otherwise, we would just die in isolation. I think this poster campaign is really going to go a long way towards drawing the communities that we want to draw in, not just during Counseling and Testing week, but beyond that."

Chair Koh, added, "What an outstanding presentation…I am very pleased that Dr. McGuire took a broad, global approach to this epidemic because we are sadly now entering the third decade of this epidemic, and we all understand that this virus has literally sent shockwaves around the world so that we now have almost forty million people infected worldwide. I think we all understand, from a public health perspective, that this epidemic affects all of us. You don't have to be infected to be affected by HIV. It is of concern that about a third of people who are HIV positive are not aware of their status, and that's why the importance of this campaign is so absolutely crucial. Dr. McGuire has underscored that too many people with HIV are diagnosed either later or not at all. We must reverse that trend because this is a very treatable infection. I think the most important part is that we are bringing testing to high risk people where they are. That is what Public Health does with publicly funded dollars, that no one else can do. Last but not least, the stigma issue, which continues to be the major challenge…We have to confirm that the enemy is the virus, not the person with the virus, and that our Public Health mission is to suppress the virus, and support people with the virus. That should be our common goal…"

Council Member George Jr., asked about the age factor. In response, Dr. McGuire said that in Massachusetts, the state has been successful in educating the youth about sexual health development, teen pregnancy, tobacco smoking and STDs so that there has not been as much HIV in the adolescent population here in Massachusetts as in other states, particularly in the southeast and west. The other end of the spectrum is the older population, over 50 years with HIV and AIDS who are staying healthier longer. Council Member Cudmore asked about the outcomes for people who do receive treatment early versus late. Dr. McGuire responded, "…People in Massachusetts get excellent HIV care regardless of their income status and that we have really done a lot to assure that class is not a barrier to quality infectious disease monitoring and control."

NO VOTE/INFORMATION ONLY

PROPOSED REGULATION: INFORMATIONAL UPDATE ON STATUTORY AMENDMENTS TO M.G.L.c.111J – LICENSURE OF ALCOHOL AND DRUG COUNSELORS REGARDING GRANDFATHERING PROVISIONS:

Ms. Alexandria Kearns, Bureau of Substance Abuse Services, accompanied by Attorney Edward Sullivan, Deputy General Counsel, presented 105 CMR 168.000 to the Council. Staff said in part, "…In September 2001, the Bureau of Substance Abuse Services held public hearings on proposed regulations at 105 CMR 168.000, entitled "Licensure of Drug and Alcohol Counselors." At the June 19, 2001 Public Health Council meeting, the Bureau provided the Council with an informational briefing on the proposed regulations, however, following the public hearings, an amendment to M.G.L.c.111J, the statute that governs the proposed regulations was filed with the Legislature that added grand parenting provisions to the original statute. The amendment was signed into law by the Governor in March as Chapter 60 of the Acts of 2002 (Act). Therefore, the Bureau of Substance Abuse Services has updated the proposed regulations to the grand parenting provisions. The grand parenting provisions provide for exemptions from certain licensing requirements for level I and level II alcohol and drug counselor licensing applicants. The exemptions account for certain professional experience, academic training, or certification or a specific combination of the three (see Chapter 60 of the Acts of 2002, attached as Exhibit 2.) These exemptions will be in place for applicants currently practicing in the Commonwealth as alcohol and drug counselors who apply for licensure within 1 year after the effective date of the regulations. The updated proposed regulations will go to public hearing on July 16, 2002. **NO VOTE/INFORMATION ONLY**

REGULATION: REQUEST EMERGENCY AND FINAL ADOPTION OF 105 CMR 950.000: CRIMINAL OFFENDER RECORD CHECKS:

Attorney Tracy Miller, Deputy General Counsel, presented the Criminal Offender Record Checks to the Council. Attorney Miller said in part, "On November 21, 2000, the Department of Public Health adopted on an emergency basis the first set of regulations entitled Criminal Offender Record Checks (105 CMR 950.000). This set of regulations was adopted as final on August 21, 2001. The Department had to modify one portion of the regulations that were adopted as final in August 2001, to comply with the findings of the court in Cronin et al. v. O'Leary. As a result, on October 4, 2001, the Public Health Council approved a request to adopt revised Criminal Offender Record Checks (105 CMR 950.000) on an emergency basis…The purpose of the regulations is to establish standardized procedures for the Department of Public Health and its contracted vendors with respect to the review of criminal records of candidates for employment or regular volunteer or training positions. The regulations require the Department and programs funded by the Department to request criminal offender record information (CORI) for every candidate who will have the potential for unsupervised contact with program clients, and to review that information to determine if the individual is appropriate to be hired under the guidelines set out in the regulations."

Attorney Miller further noted, "Since the inception of this process, the Department has also carefully evaluated the testimony from the advocate community regarding the impact of these regulations on the ability to provide peer workers particularly in recovery and AIDS programs. The Department weighed these concerns against the compelling need to insure the safety of the

potential clients, and concluded that the regulations provide adequate mechanisms to allow for an appropriate workforce. In the budget for Fiscal Year 02, language concerning CORI reviews by programs funded by EOHHS and its agencies was enacted by the legislature on December 1, 2001. Similar language is included in the pending budget for Fiscal Year 03. This language reflects many of the concerns raised by individuals and programs in their comments on the regulations. Consequently, EOHHS has worked with its agencies to develop a final set of regulations which incorporate many of the provisions in the budget language. The Department also worked closely with the Executive Office of Health and Human Services (EOHHS) as well as various agencies under EOHHS to insure careful and consistent regulations, particularly since vendors often have contracts with multiple agencies. On the basis of this analysis and review, EOHHS and its agencies are adopting final regulations with several revisions (outlined in attachment IV)."

The Emergency Regulations:

The emergency regulations established four categories of criminal offenses that might show up on a CORI check: lifetime presumptive disqualification, ten-year presumptive disqualification, five-year presumptive disqualification and discretionary disqualification:

- In the event that a candidate for employment or a volunteer or trainee position has a lifetime presumptive disqualification, that candidate will have an opportunity for consideration for employment involving potential unsupervised contact with clients. There is no set time passage that makes a lifetime presumptive disqualification candidate eligible for consideration, as there is with the 10 and 5-year presumptive categories. A candidate with a lifetime presumptive disqualification, however, may be considered for employment upon a positive assessment by a qualified mental health professional or a criminal justice official that the individual does not pose an unacceptable risk of harm to the persons served by the program. In addition, the hiring authority must also conduct a review to determine that the candidate does not pose a danger to clients.

- Candidates with a 5 or 10-year presumptive disqualification may be eligible for positions involving potential unsupervised contact with clients, but only after the 5 or 10-year period has passed or the candidate's criminal justice official or a qualified mental health professional concludes in writing that the candidate does not pose an unacceptable risk of harm. Further, the hiring authority must then conduct a review to determine that the candidate does not pose a danger to clients.

- An individual with a discretionary disqualification may be eligible for a position involving potential unsupervised client contact only after the employer conducts a review to determine that the candidate does not pose a danger to clients.

- The regulations contain a waiver provision, which allows the Department to grant an exemption from the requirements relating to the 10 and 5-year presumptive categories to a vendor agency program when the Department determines that the exemption is warranted on

the basis of consideration of the following criteria:

- The service needs and level of vulnerability of the clients served by the program
- The potential benefits and risks to those clients as a result of the exemption
- The hiring authority's capacity to perform the review required under the discretionary exemption provisions of the regulations

Programs that serve clients 16 years of age or under or a population that is primarily 65 years of age or older are not eligible for the waiver.

This waiver provision also does not apply to individuals convicted of a crime in the presumptive lifetime disqualification category.

The Final Proposed Regulations:

- All convictions that previously fell under the "Ten-Year Presumptive Disqualification" and the "Five-Year Presumptive Disqualification", (105 CMR 950.105 (2) and (3) respectively), will now be evaluated as a Discretionary Disqualification (105 CMR 950.106). These crimes have been combined and listed in "Table B". The candidate for employment no longer has to show that 10 or 5 years has passed since the final disposition of the offense or that he or she has the endorsement of the criminal justice official or a qualified mental health professional to be eligible to be considered for employment. The discretionary review applies to all candidates that previously fell in the Five, Ten and Discretionary categories. There is no distinction among these three categories with respect to the review undertaken by the hiring authority.

- All candidates that have a conviction for any crime listed as a Lifetime Presumptive Disqualification (105 CMR 950.105 (1), "Table A") are presumed ineligible; however, they are provided with an opportunity to rebut the presumption that they are ineligible pursuant to the existing provisions of 105 CMR 950.105 (1). A candidate with a lifetime presumptive disqualification may be considered for employment upon a positive assessment by a qualified mental health professional or a criminal justice official that the individual does not pose an unacceptable risk of harm to the persons served by the program. In addition, the hiring authority must also conduct a review to determine that the candidate does not pose a danger to clients. Note that language has been added to clarify that the candidate may request an assessment by a qualified mental health professional if the candidate was not able to obtain criminal justice official endorsement. This cost of this review remains the responsibility of the hiring authority.

- All decisions by the hiring authority must be in writing, documenting why the candidate is appropriate, and must be submitted to the Department (when the Department is the primary funding agency) prior to the commencement of employment. With respect to candidates that had a record of crimes listed in the former lifetime presumptive (now "Table A"), or the 10

or 5-year categories (now "Table B"), the Commissioner has five business days to disapprove of the hire (105 CMR 950.106 (3) and (4)). Candidates that have a crime listed in the former "discretionary category" (now "Table C") may be hired without waiting five days. The Department may impose the five-day review process for these candidates as well if through audit or other source, the Department determines that such review is warranted.

- The waiver provision (105 CMR 950.107) currently allows a program serving less vulnerable clients to apply for a waiver from some of the requirements for review of candidates with a condition on the five or ten-year lists. Under the final regulations, these requirements no longer exist. The revised waiver provision now allows the Commissioner to grant an exemption for these programs from the five-day review requirement for candidates who are are not in the lifetime presumptive disqualification category. A provision was added which allows the Commissioner to revoke the exemption at any time without prior written notice.

- The definition of "applicant" has been added to clarify the distinction between individuals applying for positions and those who have received a conditional offer for employment, who are defined as "candidates." While all applicants must consent to a CORI check, only candidates are subject to the review process outlined in the regulations.

- The definition of "qualified mental health professional" has been changed to remove the restriction on using qualified mental health professionals employed by the hiring authority to provide assessments. This is intended to ease the fiscal burden on hiring authorities.

In conclusion, Attorney Miller said, "The Department respectfully requests that the Public Health Council adopt the final regulations as proposed. These regulations meet the mandate required by the court in Cronin et al.v.O'Leary and are consistent with the regulations adopted by the Executive Office of Human Services and the other agencies within the Secretariat. The current emergency regulations are due to expire on July 3, 2002. The new final regulations will not become effective until July 19, 2002 due to filing and publication dates established by the Secretary of State's Office. Consequently, the Department also requests that the Public Health Council adopt the final regulations as emergency regulations which, will be filed on July 3, 2002 and will become effective immediately as of that date. In this way, as of July 3, 2002, there will be no lapse in the final regulations adopted by the Public Health Council today."

At the meeting, a revised Attachment IV was handed out with the following changes:

950.005: Definitions

Page 2
Discretionary Disqualification: A candidate shall be ineligible for a position that entails potential unsupervised contact with persons receiving services at a Department funded…

Page 5
950.102: Hiring Authority Responsibilities
(1) last line, strike "and 950.110."

Page 9
950.106: Provisions for review of a Candidate in any Discretionary Disqualifications Category
(2) correct typographical error "tot he", to read "to the"

Page 10
Change the numbering of
950.110 to 950.109 in the caption.

Page 11
Change the numbering of
950.111 to 950.110 in the caption.
Change 950.110 to 950.109, both times it appears in the text of this section.

Various spacing, bolding or unbolding changes in the table, and addition of section numbers or letters as reflected in the attached regulations.

Page 20
Change the numbering of
950.204 to 950.201 in the caption.

After consideration, upon motion made and duly seconded, it was voted (unanimously) to approve the **Requests for Emergency and Final Adoption of 105 CMR 950.000: Criminal Offender Record Checks**; that a copy be forwarded to the Secretary of the Commonwealth; and that a copy be attached and made a part of this record as **Exhibit Number 14,743**.

DETERMINATION OF NEED PROGRAM:

Note: Chairman Koh stepped out of the meeting during the briefing on the neonatal guidelines below; Council Member George acted as Chair.

INFORMATIONAL BRIEFING ON THE PROPOSED REVISIONS TO THE REVISED JANUARY 28, 1997 DETERMINATION OF NEED GUIDELINES FOR NEONATAL INTENSIVE CARE UNITS:

Ms. Joyce James, Director, Determination of Need Program, presented the Guidelines for Neonatal Intensive Care Units to the Council. Ms. James said, "…The purpose of this memorandum is to inform you of staff's plans to release for public comment proposed revisions to the Health Care Requirements section of the Neonatal Intensive Care Guidelines, otherwise known as NICUs. The revisions are included as an attachment in your memorandum, and two major changes are proposed. One is the planning for NICU services will be statewide rather than regional, as it was in the existing guidelines. The other major change is that need has been found for twenty-five additional beds by the year 2005. The revised guidelines also include criteria to establish a new NICU service or to expand an existing one. Following the public comment period, the revised guidelines will be submitted to the Council for adoption at its July 23rd meeting."

NO VOTE/INFORMATION ONLY

ALTERNATE PROCESS FOR TRANSFER OF OWNERSHIP APPLICATIONS:

PROJECT APPLICATION NO. 6-3A17 OF J.B. THOMAS, INC. – REQUEST FOR TRANSFER OF OWNERSHIP AND ORIGINAL LICENSURE OF KINDRED HOSPITAL, BOSTON, NORTHSHORE:

PROJECT APPLICATION NO. 4-3A18 OF KINDRED HOSPITALS EAST, LLC – REQUEST FOR TRANSFER OF OWNERSHIP AND ORIGINAL LICENSURE OF KINDRED HOSPITAL, BOSTON:

Ms. Joyce James, Director, Determination of Need Program, presented the two alternate process for transfer of ownership applications to the Council. Ms. James stated, "…We are recommending approval of the transfer of ownership of Kindred Hospital, Boston Northshore and Kindred Hospital Boston resulting from emergence of the corporate parent, Vencor, Inc., and its subsidiaries, now known as Kindred Hospital, Inc. and changes in the distribution of the stock there from, as part of a Chapter 11 reorganization plan and pursuant to the order of the Bankruptcy Court in Wilmington, DE."

Atty. Daria Niewenhous, of Mintz, Levin, Cohn, Ferris, Glovsky & Popeo PC, representing the applicants, thanked the DoN Office for their "cooperation and for making this a smooth and painless process".

After consideration upon motion made and duly seconded, it was voted: (unanimously) that Project Application No. 6-3A17 of J.B. Thomas, Inc.'s Request for transfer of ownership and original licensure of Kindred Hospital Boston Northshore, resulting from the emergence from bankruptcy of the corporate parent, Vencor, Inc. (now known as Kindred Healthcare, Inc.) and its subsidiaries, and changes in the distribution of stock therefrom, as part of a Chapter 11 bankruptcy reorganization plan and pursuant to the order of the Bankruptcy Court in Wilmington, DE., be approved and that a copy be attached and made a part of this record as **EXHIBIT NO. 14,744.**

After consideration upon motion made and duly seconded, it was voted: (unanimously) that Project Application No. 4-3A18 of Kindred Hospitals East, LLC's Request for transfer of ownership and original licensure of Kindred Hospital Boston, resulting from the emergence from bankruptcy of the corporate parent, Vencor, Inc. (now known as Kindred Healthcare, Inc.) and its subsidiaries, and changes in the distribution of stock therefrom, as part of a Chapter 11 bankruptcy reorganization plan and pursuant to the order of the Bankruptcy Court in Wilmington, DE, be approved and that a copy be attached and made a part of this record as **EXHIBIT NO. 14,745.**

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The meeting adjourned at 11:15 a.m.

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Howard K. Koh, M.D., M.P.H.
Chairman

LMH/lmh